

## Communication and Resolution Issue Brief

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### **Challenging and Complex Conversations with Patients and their Loved Ones After Harm Events**

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#### **Introduction**

Communicating effectively with patients about harm events in their care, especially those involving medical errors or mistakes, is a critical element of communication and resolution programs (CRPs). These harm event discussions with patients involve both sharing complex information and supporting upset emotions. Such conversations are challenging under the best of circumstances, but are especially difficult when there are added complexities related to the patient or family's personal or cultural identity, language, or family dynamics. CRPs must consider and plan for these complexities in order to provide a systematic, empathic, and patient-centered approach to the response to unexpected harm.

#### **Scope of the issue**

Adverse healthcare-related events occur more frequently and with greater severity in patients who are deaf or possess limited English proficiency (LEP). Nearly 1 million persons are functionally deaf and rely on American Sign Language to communicate. In addition, over 57 million people in the US speak a language other than English at home and 50% of these persons are considered LEP.

The communication challenges that hearing impaired and non-English speaking patients can pose for CRPs are just one example of the diversity in our patient and family populations. The United States is becoming increasingly more diverse from a cultural and religious perspective. Family dynamics are also changing, with fewer than half of children under the age of 18 living in a home with two heterosexual parents.

Over time, the well-functioning CRP will need to be skilled at recognizing and responding to different cultural and religious concerns, complex family dynamics, gender-identity and diversity, as well as situations that involve threats of verbal or physical abuse. What tools and resources are available to support CRPs when interacting with these patient populations?

#### **What are we seeing?**

Since AHRQ released the CANDOR toolkit in May of 2016, CAI faculty have engaged in dozens of communication workshops around the US with more than 300 organizations represented. The workshops take advantage of trained, professional actors who play

the roles of patients and loved ones who have experienced unexpected harm in health care, and workshop attendees are given the opportunity to practice their communication skills with the actors. The scenarios are videotaped and range from cases of minor to severe catastrophic harm, including unexpected death. Prior to the workshops, participating hospitals and health systems are queried about special or complex situations they have encountered during harm-related conversations that they wish to re-enact. The faculty then create the relevant scenarios to be utilized during the training. In addition to the enactments, the faculty solicit didactic background from content experts such as educators in the Deaf community, experienced professional interpreters, social workers who work with children of divorced parents, experts in conflict resolution and de-escalation, and counselors who assist with gender dysphoria.

To date, the most common requests for “complex” scenarios include:

- Limited English Proficiency of a patient, family member, or loved one;
- Deaf or hearing-impaired patients;
- Harmed children with divorced parents or same sex parents;
- Extremely angry or threatening patients or family members;
- Transgender patients;
- Patients with LEP and cultural or religious diversity [a Somali patient in a historically non-diverse community].

Many “lessons learned” have been realized during these workshops. Attendees of these workshops uniformly rate the experiences with these complex scenarios extremely valuable. From these trainings, we offer some general recommendations.

## Recommendations

### *Program Implementation*

- Improve the organization’s ability to capture accurate demographic data, including language preference and gender identity.
- Carefully analyze the demographics of their patients and family members, identify likely special or complex communication situations. This data should be used for planning their CRP implementation.
- Identify in advance critical personnel who can help coordinate conversations with deaf or LEP patients.
- Consider linking CRP efforts with a diverse patient and family advisory council focused on the needs of the community served, and use the council to advise or coach on the best approach in unique situations, such as gender identity.
- Develop policies, procedures, and protocols for the use of in-person interpreters versus the use of technology-supported interpretation. Significant and critical conversations seem to benefit from in-person interpreters and organizations should identify, in advance, a process ensuring interpreter availability for those circumstances.

### *Communication Training*

- Rigorously simulate complex communication scenarios with a special focus on personnel/room/seating arrangements when interpreters are utilized.
- Use video-taped enactments to highlight approaches that work well and those approaches where opportunities for improvement are experienced.
- Those who serve as communication coaches should practice using interpreters for harm conversations with patients and families in advance, so that the coaches are not trying this approach for the first time with actual patients and families.

### *Preparing for Conversations*

- The clinical personnel engaging in the communication should always consider whether there are unique personal or family dynamics, race, ethnicity or religious concerns, limited English proficiency, or any other special circumstance.
- Take advantage of pastoral services and make certain to utilize persons knowledgeable about the culture and religion of the patients, family members, and loved ones during the planning phase and the actual conversations.
- Be mindful of the need for de-escalation in situations involving patients or family members with anger management issues or demonstrating serious verbal or physical threats. This may require personnel trained in de-escalation to coach or be present in such circumstances. Knowing how to access these resources in the organization is critical.
- With non-English speaking or hearing-impaired patients, it is important that clinicians first avail themselves of qualified interpreter services, even if obtaining such supports delays this initial discussion. Ideally, the interpreter services would be provided in-person, allowing the interpreter to observe and respond to the non-verbal aspects of the discussion. When “in person” services are not available 24 hours a day, use of telephonic interpreter technology is a reasonable approach to take, as long as sufficient planning and coaching has taken place to ensure empathic communication.
- Practicing with interpreters in advance can be invaluable as the communicator speaks only a sentence or two at a time while pacing their conversations. This allows for the time the interpreter needs to accurately translate the information to the foreign language and then convert any questions back to English.
- Whilst the interpreter is conveying the information, the clinician should take advantage of the opportunity to observe for any non-verbal clues, including facial expressions, on the impact of the disclosure. While these pauses during interpretation can interrupt the natural flow of communication there is an upside of increased time for observation.

### **Summary**

The principled approach to unexpected patient harm requires organizations to adapt their communication skill sets to an increasingly complex and diverse patient and family

population. The well-functioning CRP needs to carefully and comprehensively plan for the needs and desires of their entire patient population and the community they serve.

## Resources

- Betancourt JR, Renfrew MR, Green AR, et al. Improving patient safety systems for patients with limited English proficiency: a guide for hospitals. Rockville, MD: Agency for Healthcare Research and Quality; 2012. AHRQ Publication No. 12-0041.
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- Mitchell, Ross E. "How Many Deaf People Are There in the United States? Estimates From the Survey of Income and Program Participation." *Journal of Deaf Studies and Deaf Education*, vol. 11, no. 1, 2006, pp. 112–119.
- Gretchen Livingston, "Fewer than half of U.S. kids today live in a 'traditional' family." Pew Research Fact Tank, Dec 22, 2012, <http://pewrsr.ch/1zW782T>